INVOICE
I/DD WAIT LIST SUPPORT GRANT FUND

AGENCY:	
AGENCY ADDRESS:	
Participant:	
Date(s) of Service:	

Service Provided		**Page**	**Number of Units Billed for Each Service**		**Amount for Each Service**
Service Coordination		**8**		**$9.70 unit**	
Behavioral Support Professional Day Services		**8**		**$10.41 unit**	
Supported Employment	1:1	**7**		**$7.52unit**	
	1: group	**7**		**$3.02unit**	
Prevocational Services	1:3-4	**7**		**$3.20unit**	
	1:5-6	**7**		**$2.03unit**	
Facility Day Habilitation	1:3-4	**7**		**$3.20unit**	
	1:5-6	**7**		**$2.03unit**	
Respite	1:1	**8**		**$5.01unit**	
	1:2	**8**		**$2.51unit**	
	1:3	**8**		**$1.67unit**	
Transportation *CAP =900 miles @ CURRENT MILEAGE RATE*		**8**		**$0.42mile or $8.31 trip**	
Behavioral Support Professional II		**8**		**$10.41 unit**	
Environmental Accessibility Adaptations		**8**		**$1.00 unit**	
			TOTAL AMOUNT OF INVOICE		

Please forward invoice to:
Title XIX ID/DD WAIVER SUPPORT GRANT FUND
Bureau for Behavioral Health
Division of Developmental Disabilities
350 Capitol Street, Room 350
Charleston, WV 25301
Fax: 304-558-0161

Signature and Printed Name Date

I certify that this invoice is accurate to the best of my knowledge

BBH APPROVAL ___ YES ____ NO

BBH Representative Signature **Pamela A. Ingram** Title **BHSS** Date

To the best of my knowIedge, I certify that this invoice corresponds with the approved Eligible Applicant Special Funds Application

Effective Date: September 23, 2021